COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS
239 CAUSEWAY STREET, SUITE 500
BOSTON, MA 02114
800-414-0168
www.mass.gov/dph/boards

TEMPORARY PRACTICE CERTIFICATE APPLICATION INSTRUCTIONS AND CHECKLIST

Please read these instructions carefully. All supporting materials must be submitted at the same time. Applications will not be reviewed by the Board until all documentation has been received.

General Information About the Application Process:

The Board of Registration of Physician Assistant ("Board") highly recommends that you refrain from accepting a PA position in Massachusetts until you are licensed.

Once an application is received by the Board, it takes a minimum of **3 - 5 weeks** to review the completed application and determine if any additional information is required. Once complete, applications are processed for the issuance of a license in the order received. Every effort is made to process license applications in a timely manner; however, the Board is unable to expedite the processing of applications.

To facilitate the processing of your application, please ensure that you provide all the information requested. DO NOT LEAVE BLANKS. If you are unable to provide the requested information, attach a separate sheet with an explanation. Missing information will delay the processing of your application.

As an applicant, it is your responsibility to ensure that ALL supporting documentation for licensure is sent directly to the Board and to check with the Board on the status of your application.

All requested information must be provided; failure to provide requested information may result in a delay in processing an application. Incomplete applications will be returned to applicant.

Complete applications must include the following documents:

- ☐ Completed application form with 2x2 passport style color photo and notary signature.
- ☐ Official transcripts in signed, sealed envelopes from all undergraduate programs/degrees, physician assistant programs/degrees and any other post-secondary programs/degrees. When requesting official transcripts, please inform each school's registrar that the **transcript must be complete and indicate the degree and date conferred in mm/dd/yyyy format.** Transcripts may be sent directly to the Board by the institutions. Transcripts pending completion may be accompanied by a certified letter from the Registrar's Office verifying:

  a. the completion of all requirements for a degree; and,
  b. the anticipated date of graduation. **Applicants must have graduated from a physician assistant program before a temporary practice certificate can be issued.**

  NOTE: Board statute at M.G.L. Chapter 112, § 9I requires that an applicant for licensure as a physician assistant shall provide **satisfactory proof of having received a bachelor's degree** from an accredited college or university; Board regulations at 263 CMR 3.02 (2)(b) require that any person seeking a license to practice as a physician assistant must possess a baccalaureate degree from an educational institution accredited by the US Department of Education.

☐ NCCPA documentation that you:

a. have met all the requirements for licensure as a physician assistant set forth in 263 CMR 3.04 except passing of the physician assistant certification examination administrated by NCCPA;.
b. you are registered for, and have been determined to be eligible to take, the next available administration of the physician assistant certification examination administrated by NCCPA.

The verification must be sent directly from NCCPA; email verifications are not acceptable.

☐ Verification of licensure status, in signed, sealed envelopes, from any state or jurisdiction in which you now or have ever held any professional license or board certification. Verifications must be sent directly to the Board by the state or other jurisdiction.

☐ If you hold, or have ever held, any professional license, you must request and submit a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query. To request a Self-Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or at www.npdb-hipdb.com. Include the **ORIGINAL** report with this application; make a copy for your records.

NOTE: If you do **NOT** hold and have never held any professional licenses in any other state, you do not need to submit a National Practitioner Data Bank self-query.

☐ Submission of the Criminal Offender Record Information Acknowledgement Form (CORI).

NOTE: The Board of Registration in Physician Assistants cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a DHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

☐ Supervising Physician form, if applicable. Your license may be issued without this form; however, it must be on file with the Board within thirty (30) days of beginning employment. A MA Board of Registration in Medicine Physician Profile must be attached. Profiles are available on line at www.massmedboard.org.

☐ Work Setting Information form, if applicable. Your license may be issued without this form; however, it must be on file with the Board within thirty (30) days of beginning employment.

NOTE: Multiple supervising physicians and work settings require submission of separate forms for each supervising physician and each work setting.

☐ Check or money order payable to the Commonwealth of Massachusetts for $150.00. Cash or foreign currency is not accepted. All fees are non-refundable and non-transferable.

☐ Submission of completed application and fee acknowledges that the applicant understands and agrees to all provisions herein. Applications are void if requirements for a temporary practice certificate are not met within one (1) year from the date of Board receipt of this application.

☐ Application must be submitted on single-sided paper.

☐ Retain a copy of the completed application and related documentation for your records. **The Board is not able to provide copies of the application.** Employers may require that you provide them with a copy.

☐ All submissions and documentation for agenda items must be received by the Board at the close of business on the Monday of the week preceding the scheduled Board meeting. Materials received after the deadline will be reviewed prior to being placed on the agenda for the next scheduled meeting.

IMPORTANT INFORMATION:

Pursuant to 263 CMR 3.04 (4), Board regulations state that a physician assistant applicant/registrant must notify the Board in writing of any of the following events within thirty (30) days of their occurrence: change of address of applicant/registrant; change of identity of the applicant/ registrant's employer or employment status of the applicant/registrant; any change in the identity or address of the registered physician supervising the practice of the applicant/registrant; or, the permanent departure of the applicant/registrant from the Commonwealth of Massachusetts.

Your address is a PUBLIC RECORD that is available to anyone who requests it. If you are using your home address, you may wish to consider changing this to an office address. Address changes may be done on online at the board's website www.mass.gov/dph/boards/pa or you may obtain a form online to submit to the Board's office. Retain a copy of the completed application and related documentation for your records. Employers may require that you provide them with a copy.

Answers to many questions may be found on the Board's website. Statutes and regulations governing physician assistant licensure and practice may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168.

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COMPLETE ALL QUESTIONS
TEMPORARY PRACTICE CERTIFICATE FEE - $150.00

1. Applicant Name :_____
Last First Middle
a. Maiden Name/Other Name (if applicable):
_____
Last First Middle

2. Address of Record: _____
No. Street Apt. #
_____
City/Town State Zip Code

3. Most Recent Previous Address: _____
(Different then Address of Record) No. Street Apt. #
_____
City/Town State Zip Code

4. TELEPHONE NUMBER(S) Day: _____ Evening: _____ Cell: _____

5. ____/____/____ _____
Date of Birth (mm/dd/yyyy) **Place of Birth** (city/state/country)

HEIGHT: ____ Feet ____ Inches **WEIGHT:** _____ Lbs. **EYE COLOR:**_____

Sex: M F (Circle One) **MOTHER'S MAIDEN NAME:** _____

Email: _____

6. **SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):** ____/____/____
Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. The Department of Revenue will use your SSN to ascertain whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).

FOR BOARD USE ONLY

Application Number: _____ Receipt Number: _____

Temporary Practice Number: PAT_____ Date Issued: _____

EDUCATION

7. I certify under the pains and penalty of perjury, that I have taken or I will register for and take the next available administration of the NCCPA certifying examination

Scheduled date of NCCPA Certification Exam: ___/___/_____
(mm/dd/yyyy)

Signature: _____ Date: _____

Applicant must arrange for official written documentation of certification to be sent directly to the Board by NCCPA. Request form included with application forms.

8. PA Program Name/Location: _____

_____

Degree awarded: _____ Date of Graduation:___/___/_____
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board.

Bachelor's Degree School Name/Location: _____

_____

Degree: _____ Date Awarded: _____/__/_____
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board.

Other post-secondary Institution(s)/Location(s): _____

_____

Degree:_____ Date Awarded: ____/____/____
(mm/dd/yyyy)

Submit official transcript in a signed, sealed envelope. Transcripts may be mailed directly to the Board.

Please list additional post-secondary educational institutions on a separate sheet and request that transcripts be submitted directly to the Board as noted above.

VERIFICATION OF OTHER LICENSES/BOARD CERTIFICATIONS

9. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS EVER HELD; INCLUDE ALL STATES AND JURISDICTIONS

☐ I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.

Issuing State/Jurisdiction	Profession	License/Certification Number

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board in a signed, sealed envelope.

QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

10. Have you ever been denied a license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

11 Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

12 Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

13 Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

14 Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor violations for which a fine of $250 or less was imposed.

Yes ☐ No ☐

15. Have you ever been court martialed or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Registration of Physician Assistants any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Registration of Physician Assistants to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a temporary practice certificate to practice as a Physician Assistant, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing practice with a temporary practice certificate in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for a temporary practice certificate shall be deemed no longer valid if requirements for a temporary practice certificate are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for a temporary practice certificate may be grounds for the Board of Registration of Physician Assistants to deny issuance of a temporary practice certificate and to suspend or revoke a temporary practice certificate issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent passport photo (2x2)

NOTARY NAME: _____

COMMISSION EXPIRES: _____ [Seal]

INCLUDE A NON-REFUNDABLE FEE OF $150.00 (CHECK OR MONEY ORDER) PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS

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SUPERVISING PHYSICIAN FORM FOR TEMPORARY PRACTICE CERTIFICATE AND LICENSE APPLICATIONS

Complete this form and submit it to the Board with application for Temporary Practice Certificate or License Application. If you are not employed at the time of application for a Temporary Practice Certificate or a License, return this form to the Board at the above address within thirty (30) days of beginning employment in the Commonwealth of Massachusetts. If you have more than one supervising physician and work setting, you must complete and submit a separate form for each supervising physician and each work setting.

Applicant/PA Name: _____
Last First Middle License/Temp Prac #

Applicant/PA Address: _____
No. Street City/Town State Zip Code

Date of Employment: _____

Physician Name: _____
Last First Middle License # Specialty

TO BE COMPLETED BY SUPERVISING PHYSICIAN:
List all physician assistants currently under your supervision:

Name: _____ Lic Number: _____

Name: _____ Lic Number: _____

Name: _____ Lic Number: _____

Name: _____ Lic Number: _____

If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.

I. Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

☐Yes ☐No

II. Within the last ten years form the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

☐Yes ☐No

III. Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

☐Yes ☐No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

_____ _____

Signature of Supervising Physician Date

A MA BOARD OF REGISTRATION IN MEDICINE PHYSICIAN PROFILE MUST BE ATTACHED. PROFILES ARE AVAILABLE ON LINE AT WWW.MASSMEDBOARD.ORG. SEND THE PROFILE AND THE COMPLETED FORM TO THE MA BOARD OF PHYSICIAN ASSISTANTS AT THE ADDRESS ABOVE.

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WORK SETTING INFORMATION FOR TEMPORARY PRACTICE CERTIFICATE AND LICENSE APPLICATIONS

Complete a separate copy of this form for each work setting in which you are employed as a physician assistant. If you are not employed at the time of application, return this completed form to the Board of Registration of Physician Assistants, 239 Causeway Street, Suite 500, Boston, MA 02114 within thirty (30) days of commencing employment.

APPLICANT NAME:

_____
(Last) (First) (Middle) (License/Temp. Practice #)

NAME OF FACILITY OR OFFICE: _____

ADDRESS: _____

EFFECTIVE DATE: _____

TYPE FACILITY: Office ( ) Clinic ( ) HMO ( ) Hospital ( ) Other: _____

TYPE EMPLOYMENT: Full time ( ) Part time ( )

LIST NAMES OF MASSACHUSETTS'S HEALTH CARE FACILITIES (INCLUDING GROUP PRACTICES) AT WHICH YOU WILL PRACTICE OR BE AFFILIATED WITH IN THIS WORK SETTING:

_____

_____

_____

CHECK ALL AREAS OF PRACTICE THAT APPLY TO THIS SETTING:

___ Primary Care
___ General Surgery
___ Geriatric Medicine
___ Obstetrics/Gyn.
___ Oncology
___ Administration
___ Internal Medicine
___ Education
___ Pediatrics/Adolesc.
___ Dermatology
___ Emergency Medicine
___ Occupational Health
___ Clinical Research
___ Orthopedics
___ Cardiology

___ Medical Specialty _____

___ Surgical Specialty _____

___ Other _____

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NCCPA CERTIFICATION REQUEST FORM

COMPLETE THIS FORM AND MAIL IT TO:

NCCPA
12000 Findley Road, Suite 200
Duluth, GA 30097-1409

Retain a copy for your records.

I hereby authorize and direct the National Commission on Certification of Physician Assistants, Inc., to release to the

Massachusetts Board of Registration of Physician Assistants
239 Causeway Street, Suite 500
Boston MA 02114

any and all information concerning my eligibility, examination, and/or certification status, and/or examination scores which the Massachusetts Board of Registration of Physician Assistants may require in conjunction with my application for registration. I hereby release the National Council on Certification of Physician Assistants, Inc., and its agents and employees from any liability arising out of its compliance with such a request for information.

_____ _____
SIGNATURE OF APPLICANT DATE

1A. APPLICANT NAME: _____
LAST FIRST MIDDLE

1B. PREVIOUS NAME: _____
LAST FIRST MIDDLE

2. ADDRESS: _____
NO. STREET APT. #

_____
CITY/TOWN STATE ZIP

3. DAY TELEPHONE NUMBER: _____ 4. DATE OF BIRTH: ___/__/____
(MM/DD/YYYY)

5. SOCIAL SECURITY NUMBER: ____--____--____

6. DATE OF EXAM: ____/____/____
(MM/DD/YYYY)